Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ARNOLD RAVDEL MD
PO BOX 741865
DALLAS TX 75374

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-2966-01

MFDR Date Received

May 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… Please accept the following Position Statement as required by Rule 133.307 (C)(2)(f).

(F) a position statement of the dispute issue(s) that shall include:

(i) a description of the health care for which payment is in dispute,

RANGE OF MOTION TESTING

(ii) the requestor's reasoning for why the disputed fees should be paid for refunded,

REQUIRED TESTING REQUESTED BY THE DESIGNATED DOCTOR

(iii) how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues, and

THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $111.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Chartis has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that the bill was processed correctly according to 28 Texas Administrative Code, ROM is included in the FCE."

Response Submitted by: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 13, 2011	CPT Code 95851	$111.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 14, 2012

   - 1 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 1 – By clinical practice standards, this procedure is incidental to the related primary procedure billed

   Explanation of benefits dated April 12, 2012

   - 1 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 1 – This procedure is included in another procedure performed on this date

Issues

1. Is CPT code 95851 included in the MMI/IR examination?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-RE-W8 in the amount of $700.00 with one unit and CPT Code 95851 in the amount of $180.00 with 4 units. However CPT Code 99456-RE-W8 is not in dispute.

   Review of the submitted documentation supports a request for Return to Work (RTW) exam.

   CPT Code 95851 is defined as "Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)."

   28 Texas Administrative Code §134.204 states:

   (i) The following shall apply to Designated Doctor Examinations,

   (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows,

   (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include

   (A) the examination;

   (B) consultation with the injured employee;

   (C) review of the records and films;

   (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,

   (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits)

   However CPT Code 95851 is not supported as the Range of Motion (ROM) testing is included with MMI/IR exam. Therefore no reimbursement is recommended

2. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, no additional reimbursement is recommended..

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/10/13
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.